CHILDREN WITH SEVERE EMOTIONAL DISTURBANCES

Criterion 1: Comprehensive Community Based Mental Health System

The plan provides for the establishment of a comprehensive, community-based system of mental health care for children and youth who have a serious emotional disturbance, including case management, treatment, rehabilitation, employment, housing, educational, medical, dental, substance abuse treatment, and other support services, which enable individuals to function in the community and reduce the rate of hospitalization.

Please note that the term "disability" will be used throughout as this term has its basis in various Kentucky Statutes pertaining to children in mental health services. This term is intended to be synonymous with "disturbance" as used in the federal language.

Description of the Organization of the System of Care

The Kentucky Department for Mental Health and Mental Retardation Services (KDMHMRS) administers a comprehensive, community-based system of mental health care for children with severe emotional disabilities, and their families. This is achieved by requiring the network of fourteen Regional Mental Health Mental Retardation (MH/MR) Boards, both by statute and contract, to provide a basic infrastructure of essential behavioral health services. A Regional MH/MR Board is a private, non-profit organization authorized by Kentucky Revised Statute 210 to plan and administer mental health, mental retardation and substance abuse services available to citizens in all 120 counties of the state.

A Regional MH/MR Board is required by statute to provide the following mental health services:

- Inpatient Services
- Outpatient Services
- Partial Hospitalization or Psycho-Social Rehabilitation Services
- Emergency Services
- Consultation and Education Services

To fund community mental health services, Regional Boards may raise funds locally through taxation districts, but rely primarily on Kentucky Medicaid reimbursements, state appropriations funneled through KDMHMRS, and the Center for Mental Health Services (CMHS) Block Grant allocations, private insurance and co-payments.

The state plan utilizes a combination of flexible funding and regionally based planning to extend service availability beyond the mandated array of services. KDMHMRS also recognizes that no two regions of the state have exactly the same service needs or the same barriers to accessing services. Thus, each regional board is expected to develop an array of services that is responsive to its unique needs while also striving to achieve six overarching performance measures for their

children's system of care. The performance indicators to which the Regional Boards are held accountable include:

- Penetration Rate-Children with SED;
- Penetration Rate- Rural Children with SED;
- Access to Targeted Case Management;
- School Attendance;
- Home Stability; and
- Outreach- Juvenile Justice Referrals.

The state level plan is also reflected in a revised annual Plan and Budget application process first implemented for SFY 2003. Regional Boards, in conjunction with regional planning councils (comprised of at least 51% consumers and family members), are required to specifically state their plans for development in a number of key service areas. These include:

- Family Involvement and Support;
- Mental Health Outpatient Treatment Services;
- Service Coordination and Wraparound;
- Mental Health Intensive Treatment Services; and
- Systems Interface.

This revised strategy serves to further promote the Child and Adolescent Service System Program (CASSP) principles and use of the Wraparound approach, while at the same time ensuring considerable autonomy at the regional level for service planning and decision-making. Please see the grid on the following page portraying the array of available children's mental health services by region.

COMMUNITY-BASED SERVICES FOR CHILDREN & YOUTH REGIONAL AVAILABILITY
For SFY 2004 (As reported by the Regional Boards in April 2003)

Services		Child Therapist*	Child Psychiatrist**	Early Childhood Specialist	Service Coordination	Therapeutic Child Support Services	Intensive In-Home Services	After-School Program	Specialized Summer Program	Crisis Stabilization Program	Day Treatment Program	Therapeutic Foster Home(s)	Partial Hospitalization Program	School Based Services
Regions	1	X	X	X	X	X				+++			X	X
	2	X	X	X	X	X	X		X	X		X		X
	3	X	X	X	X	X	X	X		+++		X	X	X
	4	X	X	X	X	X	X	X	X	X	X	X		X
	5	X	X	X	X		X		X	+++				X
	6	X	X	X	X	X	X	X	X	X	X			X
	7	X	X	X	X	X			X	X	X			X
	8	X	X	X	X	X			X	X				X
	9/ 10	X	X	X	X	X	X	X	X	X	X			X
	11	X	X	X	X	X	X		X	X	X			X
	12	X	X	X	X	X	X	X	X	X	X	X		X
	13	X	X	X	X	X	X	X	X	X		X		X
	14	X	X	X	X	X		X	X	X	X	X		X
	15	X	X	X	X	X	X	X	X	X		X		X

* At least 50% of time spent providing services children and families
** At least one year of specialized child training
+++Funding and operation will begin in SFY 2004

Family Involvement and Support

Introduction

It is the belief of KDMHMRS that parents' voices should help shape not only individual treatment decisions, but also program development and policy determinations at the local, regional, and state levels. This principle is strengthened by the advocacy efforts of parents at various points in the system of care. In support of this vision, significant portions of state general funds and about eight percent of CMHS Block Grant funds are allocated to parent initiatives at each level.

State Support

Within the Commissioner's Office of KDMHMRS is a Family Leadership unit. The unit, known as "Opportunities for Family Leadership" (OFL), provides numerous services for families and the systems that serve them including:

- Training in advocacy, communication, cultural competency, collaboration and legal rights in schools;
- Awarding mini-grants for parent support groups to develop local training (246 training events were funded in SFY 2003);
- Providing scholarships and stipends for parents to participate in statewide conferences as presenters and attendees; and
- Distributing reader friendly versions of Client Rights and Grievance Procedures, and supporting documents, to parents and others to ensure that these policies and procedures are understood by everyone.

Statewide Parent Organizations

Opportunities for Family Leadership was instrumental in developing two statewide parent entities, the "State Family Advisory Council" and the "Kentucky Partnership for Families and Children." It continues to provide technical assistance and support to both groups.

The Kentucky Partnership for Families and Children (KPFC), created in 1998 through the merger of two previously established organizations, has grown to over 1,500 members. Their Board of Directors is comprised of 30 members, with 60% being parent representatives. Their overarching goal is to provide support, education and advocacy to families and youth whose lives are effected by severe emotional disabilities (SED), as well as the professionals that serve them.

Activities of the KPFC include:

- Participation on numerous interdisciplinary committees to provide a voice for parents and youth;
- Dissemination of legislative handbooks and information and a no-cost, quarterly newsletter;

- Creation of a web site (***www.kypartnership.org***) and a toll free phone number for parents to access information about KPFC and resource information from across the state;
- Awarding scholarships for parents and youth to attend conferences and other advocacy events;
- Hosts parent support chat rooms twice a month, alternately serving as a time for caring and sharing among parents, and time for a question and answer session with a selected "expert" on a given topic;
- Formation of a statewide Youth Council comprised of 14-25 year olds who have an emotional disability/mental illness. This Council plans and implements strategies to reduce the stigma related to children's emotional disabilities;
- Formation of regional youth councils (2), in partnership with two community mental health centers, to replicate the model and success seen with the state-level Youth Council; and
- Operation of a toll-free Parent Resource Line for families and providers. KPFC receives approximately 50 calls per month on this line.

The State Family Advisory Council (SFAC) is comprised of parent representatives on the Local Interagency Councils (LIACs) and Regional Interagency Councils (RIACs). It serves in an advisory capacity to the State Interagency Council (SIAC) and often consults with them on a variety of issues that effect children with SED and their families.

Across all regions of Kentucky, parents' voices are most consistently heard through the LIACs and RIACs that are responsible for the identification of children with SED and for coordination of services they receive. In 1992, parents of children with SED were made statutory SIAC and RIAC members.

In 1996, OFL instituted the first of several "Family Support Initiatives." These initiatives receive guidance from OFL through a shared mission statement and outline for policies and procedures. The initiatives permit RIACs to:

- Hire a parent of a child with SED as Family Liaisons to provide peer-to-peer mentoring;
- Facilitate the creation of local parent support groups and other family member networks; and
- Provide education and technical assistance, on a variety of topics, to families and service providers.

The Family Liaisons participate in state-level peer group meetings, held quarterly, which provide them with peer support for their unique positions.

Regional Roll Up

A review of the information from the SFY 2004 regional Plan and Budget applications reveals that the parent network in most regions is well developed and

that there are ongoing efforts to maintain and increase parent involvement in a variety of ways including:

- Fifteen Family Liaisons are employed (12 full-time and 3 part-time) by the fourteen Regional Boards;
- A growing number of "grandparents raising grandchildren" support efforts are underway;
- Regions are creatively building their consumer networks and providing for parent input into programming and future planning for children's programming;
- Twelve regions have at least one active parent support group and there are five support groups across the state for transition age youth;
- Nine regions publish a parent newsletter on a regular basis;
- Ten regions have a resource library either dedicated for use by parents, or available to parents and staff; and
- Thirteen regions report the provision of educational opportunities and twelve provide parenting skills training for parents/family members, and most provide "family fun events" for children and families.

Trends/Challenges

At the state and regional level, parents of children with SED are becoming more and more involved in the development of program evaluation systems. Their participation is considered vitally important and truly gives a unique perspective. Parents act as surveyors for the Bridges evaluation system and parents are represented on several committees to create and update evaluation systems for the Family Liaison Initiatives and for the IMPACT program.

At the regional level, staffing the Family Liaison positions has became more challenging for the Regional Boards as the expectations for the positions and the skills needed to carry out the duties have became more clearly defined. While training is mandatory for the Family Liaison positions in order to maintain SIAC certification, it has become clear that a new training curriculum is desirable. Where possible, existing training workshops will be utilized to fill the revised requirements.

Strategies

Discussions are underway with Kentucky Medicaid to explore the feasibility of the Family Liaisons' interventions as a covered service under Medicaid. Therefore, OFL has initiated a series of meetings with Family Liaisons and their supervisors to update the job description and set standards for the positions. The standards will be presented to SIAC and to the Kentucky Association of Regional Programs (KARP) for approval.

Performance Indicators

KDMHMRS has developed various performance indicators for Family Involvement that are incorporated into its monitoring of regional board programs on a bi-annual

basis. These indicators generally target client and family involvement in treatment planning and access to services appropriate for addressing the needs of the child and family. On-site monitoring visits allow the Department an opportunity to discuss issues regarding access, effectiveness, quality and cost, with parents of children receiving services.

Objectives

Regional MH/MR Boards submitted the following Plans for Development in their Plan and Budget application for SFY 2004 with regard to Family Involvement:

Reg 1	Through the SKIPP program of the Center for Secialized Children's Services there will be ten (10) parent training events held that include opportunities for parent networking following the actual training events.
Reg 2	The Therapeutic Foster Care service will explore the possibility of hiring a Case Manager to work with the biological parents of the placed children in SFY 2004.
Reg 3	Have parent training sessions provided by our Parent Liason.
Reg 4	Increase family involvement by offering more in-home and community-based services. Increase the number of clinicians available to provide therapy in the homes of clients and in the community.
Reg 5	Establish a minimum of two parenting groups within the Region in SFY 2004.
Reg 6	To work with Friends of the Lighthouse to educate the community about the need for adolescent chemical dependency services and to seek additional resources.
Reg 7	IMPACT will conduct 3 Family Fun Events during the fiscal year focused on building relationships between parents and children.
Reg 8	Provide parent training using the Systematic Training for Effective Parenting program for at least 16 unduplicated parents of SED children.
Reg 9/10	Study and expand availability of parent support groups.
Reg 11	Conduct an IMPACT orientation for parents/guardians at least 1 time during SFY 2004.
Reg 12	Family Liaisons will design a region-wide training opportunity for families.
Reg13	Establish a family network throughout the region by providing family support groups in each county. The support groups will be assisted by an advisory council that will meet quarterly.
Reg 14	Maintain employment of a .5 FTE Family Support/Parent Advocate.
Reg15	All intensive Outpatient Treatment programs will offer a family support component.

It is anticipated that in SFY 2004, the grass roots approach begun in SFY 2003 will continue in an effort to enlarge the parent network and to ensure meaningful participation in regional and statewide policy-making and program evaluation.

- **Objective C-1-1:** Utilize Opportunities for Family Leadership to develop measurable outcomes and tracking tools for Family Involvement statewide. This requires consensus on a working definition for Family Involvement. Subsequently, pilot the tools at four Regional MH/MR Boards and four IMPACT Plus provider programs.

Mental Health Outpatient Treatment Services

Introduction

All but one of the Regional Boards across the state has a designated Children's Services Director. These Directors, along with others, seek to ensure that the mental health service needs of children and families in their service region are assessed, addressed and evaluated in a structured, yet flexible manner. Such services are designed to address the needs of children with SED, as well as the general population of children served in their region.

Through the research gathered and the recommendations made by the Children's Workgroup of the *Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses* (HB 843 Commission), Kentucky will undoubtedly have a stronger sense of the barriers to current services and of the service gaps that exist. This information, along with the growing research on evidence-based practices, will allow Regional Boards to better plan for the provision of effective services to all children in need.

State Support

KDMHMRS lends on-going technical support to Regional Boards to ensure adequate service delivery for children and families. Several new staff members have been hired in the Department's Children and Youth Services Branch (CYSB) over the past few years. All of these new staff are licensed mental health professionals and had previously worked for Regional Boards and for providers of various services for children with SED. Thus, they bring firsthand knowledge and perspective that is very beneficial in offering assistance to the Boards' program staff.

KDMHMRS works with Kentucky Medicaid so that essential services, like outpatient therapy (on- and off-site), case management and rehabilitation services, are available through providers employed by Regional MH/MR Boards. The majority of service descriptions, provider qualifications and billing requirements are the same or similar for KDMHMRS and Medicaid reimbursement.

Regional Roll Up

As reflected in the SFY 2003 Plan and Budget applications received from the Regional Boards, there are many ways in which board programs attempt to address barriers and needs of children and families served. These include:

- Twelve regions offer therapy appointments during evening hours in at least one of their office sites, and seven offer services during weekend hours;
- Walk-in appointments are available in all regions for children/families in crisis;
- Crisis planning is routinely included in the treatment planning process in most regions;
- All fourteen regions offer services off-site, with all offering school-based services and the majority offering in-home services in most counties; and

- All fourteen regions have a Coordinator designated for Early Childhood Services and serve children of all ages, including infants.
- Statewide, ECMH Specialists have served 392 children in the first nine months of SFY 2003.

Trends/Challenges

During the 1998 Kentucky General Assembly, KDMHMRS received an additional $1.5 million appropriation for the Community Medications Support Program (CMSP). This allocation included approximately $375,000 to expand coverage to children for the first time. The goal of the program is to assist children with SED who are living in the community and who have no other means of purchasing prescribed psychotropic medication. Prescriptions are filled at local pharmacies for a nominal dispensing fee, then the medications are replaced by the pharmacies at state-operated or contracted hospitals. The program is available in all regions.
Challenges for management of the CMSProgram in the coming year include:

- Accessing information related to what medications are most appropriate and effective for treating children with SED;
- Examining and encouraging prescribing practices that are in accordance with evidence-based practices or promising practices; and
- Determining who is best able to reasonably procure needed medications which can
  maximize the limited allocations for the program.

Regions across the state are providing more school-based services, yet it is challenging to offer these services in a cost-effective manner, as there is lost time due to travel and the logistics of providing off-site services. Many of these programs currently rely on partial grant funding and sustainability is an issue being addressed in several ways. Continually educating and seeking the support of schools and other agencies about services and their benefit is one way to ensure services continue. Sharing of information among and between regions has proven helpful as these programs evolve.
According to a recent survey by the University of Kentucky, only 2 percent of the approximate 10 percent of Kentucky's adolescents, ages 12-17, receive the substance abuse treatment needed. The difficulty in serving children with substance abuse disorders is partially attributed to the lack of funding for this service (e.g., Substance abuse treatment is not a covered service for children through Medicaid). Regional Boards are working to train staff to assess the use and abuse of alcohol and drugs by youth in their care and are often called upon to incorporate substance abuse treatment into the mental health services that they provide. There are limited residential services for youth in Kentucky as well.

Strategies

KDMHMRS, along with its partner agencies, continues to pursue expansion or increased effectiveness of successful “model” programs, including the Community

Medications Support Program, services for children ages 0-5 and outpatient services delivered in the community (e.g. client homes, schools, child care facilities, etc.).

Early Childhood Mental Health

The Early Childhood Mental Health (ECMH) Initiative, an expansion of the Governor's Early Childhood Development Initiative, KIDS NOW, began in SFY 2003 and has provided funding for each Regional MH/MR Board to hire an ECMH Specialist to work with children age 0-5 years and their families, providing assessments, consultation, and direct treatment services. They primarily work with children who are in a child care setting, and are available to provide training and consultation services to local public health departments and their early childhood personnel, private physicians, the staff of community childcare programs and of the Regional Boards.

All of the Specialists have received some basic training in working with the 0-5 population. In April 2003, the Specialists and thirty-six other clinicians from the Regional Boards attended the Infancy and Early Childhood (IEC) Training Course offered annually by Dr. Stanley Greenspan. It is hoped that through this and other collaborative training efforts, the capacity for regional clinicians to serve children 0-5 and their families will continuously improve.

Currently there are numerous school-based mental health initiatives across the state. Various models for school-based and "off-site" service provision continue to be studied and assessed for feasibility and effectiveness. KDMHMRS has sponsored several training seminars featuring national presenters to educate personnel of the Regional Boards and school districts. These have been well attended and help to keep the momentum going.

One region of the state has been awarded a Robert Wood Johnson grant to address the dually diagnosed (mental illness and substance abuse) youth in a four-county area of southeastern Kentucky. "Reclaiming Mountain Futures" is a collaborative effort between Kentucky River Community Care, the local court system and the school districts. It incorporates the team approach and wraparound model building on strengths to address the needs of the child and family.

Kentucky was also awarded a $100,000. federal grant from SAMHSA for developing effective mental health and substance abuse response systems for use in natural and man made emergencies. The funds will be allocated to the fourteen Regional Boards so that more of their staff can be trained as crisis responders and for the development of regional mental health and substance abuse emergency response plans.

Performance Indicators

There are no chosen indicators for this area.

Objectives

Regional MH/MR Boards submitted the following Plans for Development in their Plan and Budget application for SFY 2004 with regard to Mental Health Outpatient Treatment Services.

Region	Mental Health Outpatient Treatment
1	Expand number of counties where direct access to the Early Childhood Mental Health Services there will be ten (10) parent training events held that include opportunities for inter-parent networking following the actual training events.
2	Evaluate the assessibility of staff to provide and expanded presence in the school systems.
3	Develop formal agreements with school systems.
4	Added the early childhood mental health specialist who will 1) increase services to children age 0-5, 2) provide training to other clinicians to do the same, 3) increase community awareness regarding mental health issues for young children.
5	Minimum weekly on-site presence of psychiatrist for medication management at Children's Crisis Stabilization Unit during SY 2004.
6	To maintain the same penetration rate for children's outpatient in the face of reduced resources.
7	The Early Childhood Mental Health Specialist will conduct at least quarterly meetings for a core group of clinicians who will be seeing children ages 0-5.
8	Integrate the Columbia Teen Screen assessment instrument into the current system of care in order to improve the quality of assessment/initial screening. Instrument introduced by 10-03 into the current system.
9/10	Continue to establish and expand Early Childhood Mental Health services.
11	Increase school-based services to 2 additional schools.
12	Child and Adolescent staff will be provided training on substance abuse and dual diagnosis assessment and skill-building.
13	Children's Early Childhood Mental Health Specialist will provide quarterly training to identify clinicians who will assist in out patient mental health treatment for children ages 0 - 5 years. Achieved by June 2004.
14	Maintain current level of child clients served at 4,150 during SFY 2004.
15	Provide at least one training event for staff on working with early childhood (age 0-5 years) problems.

- ***Objective C-1-2:*** Share relevant evidence-based practice research with Regional MH/MR Boards to assist them in determining effective service delivery methods for use in their child and family programs.

- ***Objective C-1-3:*** Share regional information collected during the 2004 Plan and Budget Application process with regional children's planners to allow them to pool knowledge and resources.

- ***Objective C-1-4:*** Research alternative processes to manage existing resources within the Community Medications Support Program.

<u>Service Coordination and Wraparound</u>

Introduction

In Kentucky, targeted case management for children through the Kentucky IMPACT program is referred to as "Service Coordination" provided by "Service Coordinators." Kentucky IMPACT is a strengths-based, highly individualized, and collaborative model of case management utilizing the wraparound approach to address needs across life domains. These life domains include family, financial, living situations, educational/vocational, behavioral/emotional, psychological, social/recreational, health, legal, cultural and safety.

"Building Bridges of Support: One Community at a Time" (the "Bridges Project") is a six-year Comprehensive Community Mental Health Services for Children and their Families grant, awarded to KDMHMRS in October 1998. The funds are contracted it out to three Regional MH/MR Boards, Mountain (Region 11), Kentucky River (Region 12) and Cumberland River (Region 13). Each of these Appalachian regions is extremely rural, with high rates of unemployment, poverty, substance abuse and school drop-out.

The major goal of the grant is to redesign and enhance a comprehensive system of care for children with SED, and their families, by building on Kentucky IMPACT through increasing the involvement of schools in the service delivery system. Staff within the Division of Mental Health hold key grant staff positions, and OFL serves as the family organization contact for the project.

State Support

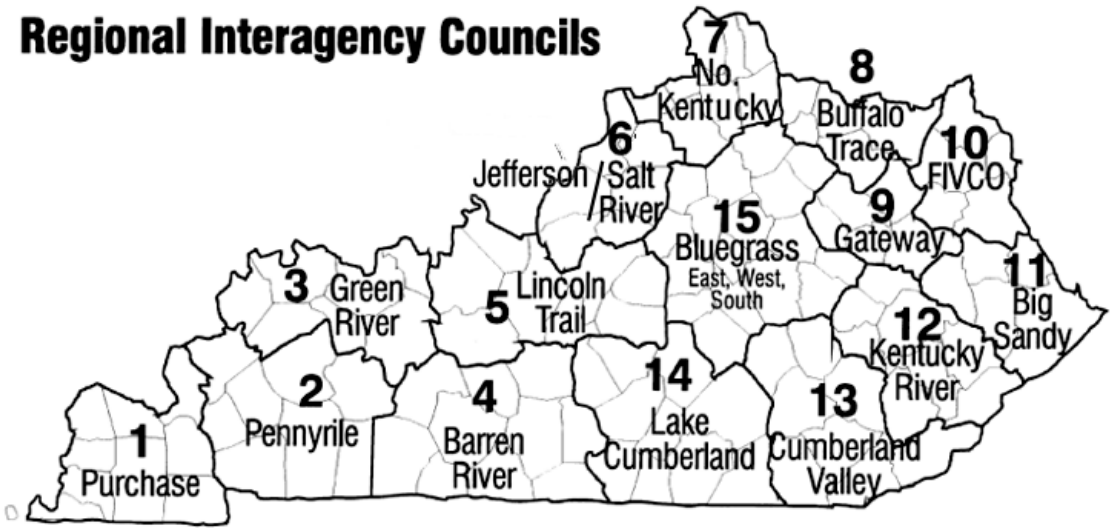
Both KDMHMRS and Kentucky Medicaid help to ensure the integrity of IMPACT's Service Coordination program standards by:

- Requiring Service Coordinators to complete certification training conducted by KDMHMRS within six months of their employment;
- Imposing caseload size restrictions;
- Prohibiting Service Coordinators from providing billable services other than Case Management;
- Requiring Service Coordinators to have a minimum of four client-related contacts per month, two of which must be face-to-face contacts with the child and his/her family, for a reimbursable service; and
- Defining what does and does not constitute an appropriate case management activity.

KDMHMRS provides technical assistance to Local Resource Coordinators (LRCs) that manage the IMPACT programs by assisting with quarterly peer meetings attended by the LRCs, SIAC staff and CYSB staff from the Department. Department staff also offers on-going technical assistance and consultation to RIACs, LRCs, Service Coordinators and others.

Legislation enacted in 1990 created eighteen Regional Interagency Councils (RIACs) that govern the regional IMPACT programs (see map below.) Each RIAC is comprised of local representatives from the primary child serving agencies and a parent of a child with SED. An LRC serves as staff to the RIAC, and generally

manages the regional IMPACT program. While the Regional MH/MR Boards employ the LRC and the IMPACT staff, each RIAC creates and monitors program policy and procedures and provide on-going consultation to the staff of their IMPACT program.



Each RIAC serves as the gatekeeper for children entering and exiting IMPACT services. Each RIAC receives an annual lump-sum allocation from KDMHMRS for Service Coordination, RIAC staff support, resource development, and Wraparound Services. In consultation with its corresponding Regional MH/MR Board, each RIAC determines how the funds will be obligated for the required services. Eligibility criteria for acceptance of a child into IMPACT is not determined by insurance coverage or a family's ability to pay.

Wraparound services may consist of the purchase of needed goods and services when there is no other available resource. Services may take the form of therapeutic interventions provided to children by trained professional or paraprofessional mentoring staff. Regional MH/MR Boards act as the fiscal agents for the funds but, again, decision-making authority regarding the use of these funds rests with each RIAC.

A ten-year evaluation report completed in September 2001 confirms the efficacy of the IMPACT program. The purpose of the study was to gather and analyze information to determine the effectiveness and evolution of IMPACT over its ten years of existence. Summary results indicate notable achievements including the following:

- Strong evidence exists that participation by a child in Kentucky IMPACT continues to be associated with statistically significant reductions in behavioral problems;
- Participation in IMPACT is associated with social competence gains;

- Participation in IMPACT appears to be associated with both parental skill development and full participation in the service delivery process; and
- The program continues to have strong social validity. Children, parents, Service Coordinators and teachers all perceive improvement in all six areas measured, including behavioral self-control, emotional adjustment, school adjustment, and family adjustment.

The Bridges Project takes the system of care for children with SED and their families forward by placing Student Service Teams in eighteen schools across three regions in southeastern Kentucky. The Division of Mental Health has contracted services for this project to the three Regional MH/MR Boards, Mountain (Region 11), Kentucky River (Region 12) and Cumberland River (Region 13). A Student Service Team consists of an Intervention Specialist, a Student Service Coordinator, and a Family Liaison, who are employees of the Regional Boards. The team members have their offices in schools selected to be part of the Bridges Project, enabling them to become familiar with, and be a part of, the school climate. This has helped reduce the stigma children may experience associated with receiving mental health services, especially in these rural areas. Additionally, this arrangement has allowed Bridges and school staff to work closely together and collaborate on a more informal basis.

Bridges encompasses pre-kindergarten through high school classroom settings and alternative school campuses. A host of training opportunities is offered across the three regions for and by parents and professionals to foster a greater sensitivity to cultural norms in rural Appalachia and to improve effective utilization of indigenous resources.

Grant staff are working collaboratively at the local and regional level with local civic groups, child-serving agencies, businesses, faith-based organizations, and other groups to identify areas for expansion, as well as sources for funding currently non-sustainable components of the grant when federal funding ends after September 2004. Additionally, regional project directors are offering training and technical assistance to children's directors in the other eleven regions of the state. This consultation includes:

- The system of care philosophy and guiding principles;
- The wraparound approach; and
- Enhancing current services through incorporating components of the Bridges Project into existing school-based mental health initiatives.

Regional Roll Up

As reported by the regions, Service Coordination is provided to:

- Individuals with co-occurring Mental Health/Mental Retardation diagnoses;
- Individuals with co-occurring Mental Health/Substance Abuse diagnoses;
- Individuals with Pervasive Developmental Disorders, including Autism;
- Transitioning and Homeless Youth; and,

- Two additional regions report that they are exploring the feasibility of implementing the Bridges model in their area.

Trends/Challenges

Evidence-based practice indicates that targeted case management services for children and families, utilizing a Wraparound approach and individualized service plans developed by a team including parents as expert participants, lead to optimal outcomes. Flexible funding availability is also a desirable component of the service model. Additional flexible funding is a goal.

Strategies

Continual support of Kentucky IMPACT is provided to ensure that services remain effective and that program improvement is always sought. Plans are underway to revise the IMPACT Evaluation system to a comprehensive Outcomes system that can be used at the local level to assist staff with treatment and program planning. The first step will be to develop child and family outcomes and identify indicators. Subsequently, there are plans to develop program and system level outcomes and indicators.

Bridges utilizes a three-tiered service model of intervention (universal, targeted, and intensive) in the schools. This is the same model used by the Kentucky Center for School Safety and the Kentucky Department of Education in schools participating in the Kentucky Instructional Discipline and Support (KIDS) Initiative. At the state level, these agencies, as well as the Department for Juvenile Justice, the Office of Family Resource and Youth Service Centers, and the Department for Public Health all support the use of this multi-tiered, comprehensive, and integrated model of service delivery.

State level Bridges Project staff frequently provides information about the model development and implementation to audiences both within and outside of the state. Additionally, collaborative work is being done with other child-serving state agencies and advocacy groups to identify possible sources of funding for continuation.

The Kentucky Bridges project has been widely recognized at the state and national level as an innovative and effective model of collaboration between mental health and schools. Through participation in national multi-site evaluation, Kentucky has and will continue to expand upon the research base regarding children with SED and system of care outcomes that it has accumulated over the past twelve years.

Kentucky implemented **IMPACT Plus**, a behavioral health program for Medicaid eligible children with complex behavioral healthcare needs, on January 1, 1998. This program culminated from two years of collaborative planning between the Kentucky Departments for Medicaid Services, Community Based Services, KDMHMRS, parents, and stakeholders. It was developed IMPACT Plus to increase the variety and availability of community-based service options and to decrease the need for inpatient care. Kentucky's development of IMPACT Plus

signals a renewed commitment to the development and expansion of community-based mental health services.

Through IMPACT Plus, Kentucky Medicaid reimburses KDMHMRS and the Department for Community Based Services (DCBS) for Medicaid billable services they purchase. KDMHMRS and DCBS in turn sub-contract with mental health agencies and private mental health professionals across the state to provide a wide network of traditional and innovative behavioral health services.

IMPACT Plus staff recruit direct service providers, assist with training of providers, track service delivery and expenditures, and perform quality assurance activities.

IMPACT Plus services include:

- Targeted Case Management;
- Outpatient Services (individual, group, and collateral);
- Therapeutic Child Support Services (behavior modification, mentoring);
- Parent to Parent Support Services;
- Partial Hospitalization;
- Intensive Outpatient Services;
- Day Treatment;
- After School and Summer Programs;
- Residential Crisis Stabilization;
- Therapeutic Group Residential Care; and
- Therapeutic Foster Care.

To date, IMPACT Plus has:

- Developed a quality improvement process and committee structure;
- Implemented a process for provider screening and credentialing;
- Implemented an Outcomes Information System to track outcomes by individual child, provider, and the overall program;
- Developed a Clinical Advisory Committee to identify best practices and processes for implementation across the provider network; and
- Increased site review efforts to ensure quality service provision.

A basic premise to IMPACT Plus is that cost savings realized from decreased rates of hospitalization and other restrictive levels of care would be redirected to support community-based service provision. Management staff from the participating Departments continues to closely monitor program expenditures and adherence to this “cost neutrality” principle.

The rapid growth of IMPACT Plus during the past six years has necessitated a number of program modifications. KDMHMRS and DCBS, along with Kentucky Medicaid, have developed new policies and processes for eligibility determination, service authorization and quality improvement. The concept is based upon the following:

- The need to "size" the program;
- The need to transition children to, and maintain them in, their own homes and communities;
- The belief that services should be goal oriented, time limited, and evidence-based;
- The desire to hold providers accountable for attaining goals;
- The need to standardize services and reimbursement for services; and,
- The belief that expenditures for children should be based upon their needs.

Performance Indicators

One indicator has been selected to measure the performance of regional systems of care with regard to children with SED who receive targeted case management services. The measure for this indicator is the percentage of children, with SED, who receive a targeted case management service based on federally established prevalence.

Please see Appendix A - Access to Targeted Case Management - Children with Severe Emotional Disabilities

Objectives
Regional MH/MR Boards submitted the following Plans for Development in their Plan and Budget Application for SFY 2004 with regard to Service Coordination and Wraparound Services.

Region	Service Coordination and Wraparound
1	Assess and determine the barriers to successful recuiting and retention of Clinical Assistants who provide mentoring services.
2	In order to continue this service, the Pennyroyal Center must have competitive salaries for recruitment and retention of Service Coordinators.
3	Make Parent Liaison available to families of patients discharged from inpatient to help with IMPACT referral
4	Continue to increas TCS by adding group TCS in counties. Increase to 5 regionally.
5	Service Coordinators will maintain on the average 90% of caseload capacity over FY04.
6	To increase by 2% the number of children/youth who receive Service Coordination.
7	Service Coordinators will participate in one "professional day" conducted by the LRC that will focus on practice skills, ethics, and handling difficult clients.
8	Develop a parent informational component regarding IMPACT services for all entries into the program. Included in this component will be videotaped introduction of personnel, service team meeting structure, service array and successful exit. Target date of incorporation into the current system 12-03.
9/10	Reconsider most effective use of wraparound funds.
11	Quarterly wraparound refinement training will occur for IMPACT and Bridges Service Coordinators
12	Specialized training and supervision will be made available for Service Coordinators working with the early childhood and child rape crisis programs.
13	All therapeutic child support staff involved in respite type services will be trained in CICM, CPR, and First Aid Training prior to providing services with a child. Assessed by June 2004.
14	Maintain current number of children (438) served and 22 FTE Service Coordinators
15	Percentage of children with SED who receive TCM by estimated prevalence will increase.

- **Objective C-1-5:** Provide statewide training and technical assistance to Regional MH/MR Board staff and local education authorities in implementing components of the three-tiered model of positive behavioral interventions and supports, as utilized in the "Bridges Project" to address mental health needs of children in school settings.

- **Objective C-1-6:** Use the School Mental Health Coalition and Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders, and Dual Diagnoses as opportunities to provide education about the three-tiered model of positive behavioral interventions and supports, as utilized by the “Bridges Project," and outcomes data. This will assist in the development of plans for replicating this model across the state.

Mental Health Intensive Treatment Services

Introduction

KDMHMRS encourages the development of Mental Health Intensive Treatment Services that aim to prevent hospitalization or provide aftercare for children who need intensive therapeutic interventions because of the severity or complexity of their disabilities. These services include, but may not be limited to:

- Intensive Outpatient and In-Home Services;
- Therapeutic After School Programs;
- Special Summer Programs;
- Intensive Group Treatment;
- Crisis Stabilization Services;
- Mental Health Day Treatment;
- Therapeutic Foster Care;
- Partial Hospitalization; and
- Psychiatric Hospitalization.

State Support

KDMHMRS provides technical assistance to Regional Boards in developing, evaluating and improving intensive mental health services by:

- Facilitating peer group meetings for Board staff dedicated to program areas;
- Including program specific training opportunities at state supported conferences for providers and consumers of intensive services;
- Assigning program areas to staff within the Children and Youth Services Branch of the Division of Mental Health so that they are aware of the most up-to-date information and research on program areas and related issues; and
- Sharing information electronically and through periodic mail-outs to the program managers on a regular basis.

Kentucky's 1994 initiative to decriminalize mental illness served as the cornerstone for the development of Crisis Stabilization Services. KDMHMRS joined with the Kentucky Association of Regional MH/MR Programs to advocate for and successfully expand funding for crisis programs.

Mental Health Day Treatment programs build on the flexibility of the Kentucky Medicaid and KDMHMRS psycho-social rehabilitation for children benefit. In SFY 1999, the Division of Mental Health began working collaboratively with the Kentucky Department of Education (KDE) and the Kentucky Educational Collaborative for State Agency Children (KECSAC) to

develop a statewide network of Mental Health Day Treatment Programs. Additionally, KDMHMRS has provided information and support to KECSAC as they seek to increase their funding so that new and expansion programs may receive State Agency Children's Funds (from KECSAC) in the future. The Department anticipates the continuation of this collaborative effort into SFY 2004.

Regional Roll Up

As reflected in the SFY 2004 Plan and Budget applications received from the Regional MH/MR Boards, there are many ways in which Board programs address intensive treatment needs of children with SED. These include:

- During SFY 2003, there were approximately fifty-five Therapeutic After Schools Programs offered in eight regions and seventy-two Specialized Summer Programs in thirteen regions across the state;

- There are more than twenty Mental Health Day Treatment programs, some of which are receiving State Agency Children's Funds from KECSAC;

- Therapeutic Foster Care is available through the Regional MH/MR Boards in seven of the fourteen regions and at least two other regions are exploring the feasibility of starting these services. Many additional providers are funded through IMPACT Plus or contracted by the state's child welfare agency; and

- Crisis Stabilization Programs are operating in twelve of the fourteen regions and the other two are in the planning stages of beginning these services. Additional funding has been proposed in the state budget for $2 million in SFY 2003 and $4 million in SFY 2004 to complete Kentucky's crisis stabilization network for children and adults.

Trends/Challenges

The regional availability of Mental Health Intensive Treatment Services is limited by the scarce availability of start-up funds. Regions also struggle with the cost of conducting data collection and evaluation of these varied and unique programs.

In order to meet the needs of children and families and develop services along a continuum, it is necessary to ensure reimbursement for "non-traditional" services. KDMHMRS continues to collaborate with Kentucky Medicaid and the Regional Boards to provide financial feasibility for needed services that may not be fully funded like therapeutic foster care and respite services.

Kentucky Medicaid and KDMHMRS first covered Intensive In-Home Services in 1990 as an expansion of clinic-based Outpatient Services. With "collateral" services to parents, family members, and other child-care providers, Kentucky's clinical outpatient services may be deployed in home, school, and other natural settings.

Strategies

KDMHMRS, along with its partner agencies, continues to pursue expansion or increased effectiveness of less restrictive services including crisis stabilization services, day treatment, and therapeutic foster care.

KDMHMRS is strongly dedicated to serving children in the least restrictive environment possible, while ensuring that they receive needed treatment. This means providing services in homes, schools, and communities, allowing children and families to maintain daily routines and living situations to the extent possible. It also means that providers of intensive services need to be keenly aware of best practice protocols and methods for evaluating effectiveness of interventions.

In the past couple of years, Division staff has attempted to heighten its consultation and support to the regional Treatment Foster Care (TFC) programs. The research supports that TFC is a desirable alternative to more restrictive out-of-home placement. Funding for these services remains limited and thus the Boards are dependent on negotiated contracts with the child welfare agency and on Medicaid funding through the IMPACT Plus program (if they are an enrolled providers, which several are not). Providing this service under the large umbrella of the Regional Boards does prove effective due to the many other therapeutic and support services available to the children, foster families and families to which the child may be returning.

Performance Indicators

There are no chosen indicators for this area.

Objectives

Regional MH/MR Boards submitted the following Plans for Development in their Plan and Budget application for SFY 2004 with regard to Mental Health Intensive Treatment Services.

Region	Mental Health Intensive Treatment
1	Expand the Partial Hospitalization Program census capacity from 16 to 24 per day.
2	Study the potential for developing a pilot after school program in the region.
3	Recruit four new Therapeutic Foster Care families.

4	Recruiting individuals to provide more intensive services in home and community. Currently have four and continuing to recruit. Will try to get to six.
5	Increase the number of Children's Crisis Stabilization Unit referrals to off-site therapy for intensive in-home aftercare services.
6	To maintain Crisis Stabilization Unit (CSU) and Mental Health Day Treatment services through a focus on financial improvement, especially in light of CSU rate cut.
7	The School-Based Coordinator will conduct a specialized summer program in collaboration with the Covington Schools.
8	Provide information and training to clinicians on research based practices of mental health treatment through training and newsletters.
9/10	Develop use of outdoor activities in intensive after school / special summer programs.
11	Expand after school programs from 1 to 4.
12	Intensive after school programs for dually diagnosed youth will be available in four of the eight counties.
13	After School and Summer programming will be available at each office site, based on need by June 2004. Programs will function year round to provide continuity of care. Assessed June 2004.
14	Maintain number of children served through Day Treatment at 35.
15	Develop standardized admonition/termination criteria for after school programs.

- **Objective C-1-7:** Expand the availability of crisis stabilization services to all fourteen regions by the end of SFY 2004.

- **Objective C-1-8:** Assist Regional MH/MR Boards in implementing crisis stabilization programs through statewide technical assistance meetings to be held a minimum of three times per year.

- **Objective C-1-9:** Assist Regional Boards in implementing therapeutic foster care programs through statewide technical assistance meetings to be held a minimum of two times per year.

Systems Interface

Introduction

Physical Health

Regional MH/MR Boards are required to assess the physical health of each consumer they serve. Clinicians and case managers work closely with parents, community primary care providers, local Health Departments, other health care providers, and schools to address the overall health needs of children.
Case management services seek to increase access to and follow-up with physical health care for children with SED. Access to transportation, knowledge of low or no cost resources, and a holistic treatment approach add to improved access. Case management wraparound funds may also be used to purchase physical or dental health services that are not otherwise available to a child. Physical health services are available through Kentucky Medicaid or the Kentucky Children's Health Insurance Program (KCHIP). Public Health is represented on the SIAC and on sixteen of the eighteen RIACs.

KDMHMRS staff continues to work towards creation of a plan for integrating physical health and behavioral health services for children. Progress is slow, yet continued study of models across the state and the nation, along with developing relationships among stakeholders, will lead to progress in this arena. Utilization of the *Bright Futures In Practice: Mental Health Series* is being encouraged for pediatricians in the public and private sectors. (See www.brightfutures.org.)

Dental and Vision Care

For dental care, access to low or no cost services provided by the University of Louisville and University of Kentucky dental schools serve as a resource in urban areas. Once again, case managers and clinicians that have knowledge of local resources and well-developed relationships with providers tend to lead to better access to dental services. However, overall access is generally considered poor. The Department does have representatives on several committees exploring dental services to children and how best to ensure outreach and treatment services to young children and children in the custodial care of the state.

Per legislation enacted on July 15, 2001, all Kentucky children are required to have an eye exam by a Board Certified Optometrist before they enter school. This is in addition to the requirement for immunizations and hearing screenings.

Educational Services

Many children served by the Regional Boards have been identified in their school districts as having an emotional/behavioral disability (EBD). Once identified as EBD, children are reviewed by an Admissions and Release Committee (ARC) which includes representatives from the child's school, parent(s), and other involved community representatives. The purpose of the ARC meeting is to identify what the most appropriate educational placement is for the child, as well as other services that might benefit the child and family. The team develops an Individual Education Plan (IEP) that is implemented by relevant agencies and community supports, when applicable. The IEP is coordinated with the child's IMPACT Service Plan or clinical plan of care, so that all involved parties are aware of what interventions and services are being provided to the child and family.

IMPACT Service Coordinators work closely with school personnel to ensure that IEP plans and IMPACT Service Plans are congruent. Clinicians often act as consultants to school personnel. A shortage of Special Education teachers in the state has increased the need for this service. All Regional Boards collect data concerning the education status of clients at intake and update this information annually. More information about mental health coordination with education is provided in Criterion 3.

Child Welfare and Legal Interface

Regional MH/MR Boards give priority to clients referred by the Department for Community Based Services and the Department for Juvenile Justice. In many areas, formal and informal collaborative meetings are held to discuss treatment

planning for shared clients. Clinicians also offer mental health consultation to the staff of these two Departments. Child welfare and juvenile justice are represented on the SIAC and all RIACs.

Substance use/abuse among children and adolescents, and their caregivers, is often identified by regional board clinicians as a contributing factor to the mental health needs of clients they serve. The use and abuse of nicotine, alcohol, inhalants, prescription and illegal drugs is addressed in the treatment provided. Clinicians and case managers also utilize education (prevention and intervention), treatment and referral mechanisms available through school districts, law enforcement agencies, private providers and Regional MH/MR Board Prevention programs.

The State Interagency Council

The SIAC is a multi-agency collaborative body created by Kentucky statute to determine and establish policy for children with SED. Representatives of key state agencies that work with children, as well as a parent representative, serve on the Council. Please see Criterion 3 for membership listing.

State Support

SIAC meets monthly and is staffed by the Division of Mental Health. An annual plan is created, as well as a year end report. This SIAC Annual Report may be accessed at

http:dmhmrs.chr.state.ky.us/mh/siac/docs.asp. The composition of SIAC and the dedication to collaboration allows for stakeholder representatives to address issues from Prevention and Early Childhood to Youth Transitioning to Adulthood services, the development of a full array of services along a comprehensive continuum of care, as well as addressing gaps and continuity of care issues.

Regional Roll Up

A review of the SFY 2004 Plan and Budget applications from the Regional MH/MR Boards reveals that systems interface occurs in many ways. Still, there is continued need for development and greater integration of the systems in which children and families operate.

Also reflected in the SFY 2004 Plan and Budget applications, the following services are available to youth in need of substance abuse treatment:

- Thirteen regions offer outpatient services;
- Three regions offer inpatient services;
- Seven regions have drug screen testing available for youth under age eighteen; and
- Ten regions provide training regarding the warning signs of substance use/abuse to clinicians working with children and families.

Trends/Challenges

It is recognized at the state and regional level that services for children and families must be delivered in a holistic manner. A child with SED often struggles to achieve academically, and there must be close collaboration between mental health treatment providers and educators on behalf of the child. For children who may be victims of or at risk of abuse or neglect, attention must be given to collaboration between mental health treatment providers and child protection. Services for children with dual diagnoses (including mental health and mental retardation and mental health and substance abuse) must also be well coordinated.

Strategies

Public Health is now represented on the RIACs by local Health Departments and their membership has proven invaluable. To help focus on improving access to physical health and dental services, a representative of the Department for Public Health has also joined the Kentucky Mental Health Services Planning Council.

Kentucky ranks 36th in the nation in terms of childhood wellness. Approximately 1,500 School-Based Health Centers exist nationwide, with 22 of those located in Kentucky.

Performance Indicators

There are no chosen indicators for this area.

Objectives

Regional MH/MR Boards submitted the following Plans for Development in their annual Plan and Budget application with regard to Systems Interface.

Region	Systems Interface
1	Establish a programming option that includes interventions for youth with co-occuring substance abuse issues.
2	Improve interagency communications to better serve the needs of the regional children with SED.
3	Expand current day treatment programs.
4	Will add a physical health screening to psychosocial evaluation and include referrals to primary care physicians when indicated.
5	Increase collaborative contacts (at least quarterly) to Public Health agencies to increase referrals for children's services.
6	Continue with SAMHSA Board of Directors, and RIAC activities monthly.
7	Our Intensive Services and ACCESS unit will track the length of time from discharge to first outpatient appointment at NorthKey, and make this data part of the regular statistical report generated by the ACCESS unit.
8	The school-based mental health advisory committee and House Bill 843 Children's Services Array Subcommittee will meet quarterly to discuss the status of programs and to provide continued input into the service delivery system.
9/10	Increase collaboration with Headstart & Public Health in Early Childhood Mental Health Initiative.
11	Collaborate with 2 school systems to implement summer programs in the schools.

12	Community interagency groups will meet in four of our eight counties to identify and develop plans to address the substance abuse/dual diagnosis needs of youth.
13	The Regional Interagency Council and the Local Interagency Council will have required representation and/or alternate to attend monthly meetings by January 2004.
14	Maintain current level of effort and quarterly meetings with Department for Community-Based Services (DCBS) staff.
15	Increase referrals from Department for Community-Based Services (DCBS).

Comments from the Planning Council Members at their August 14, 2003 meeting:

One Council member stated that he didn't see any connection between the objectives and the performance indicators.

Staff explained that some objectives were more directly linked with performance indicators, however, most objectives were specific initiatives that were to be carried out at the state level that should assist the system meet its projected performance indicator targets.

One member stated that he thought Kentucky was doing a better job that any other state (by 50%) with the limited amount of block grant dollars.

Staff agree that the Regional Boards, with limited funding, have improved the system of care for adults with severe mental illness over the past several years.

The Department for Public Health representative stated that he liked seeing the term "epidemiology" in this plan. He hopes that this and future plans will continue to explore the causes of mental illnesses and address prevention. He also stated that he was glad to see that bio-terrorism was addressed in the plan and suggested that an objective be added related to the involvement of each Regional MH/MR Board with their community's response to potential terrorist emergencies.

Given the recent receipt of a $100,000 SAMHSA grant designed to address CMHC readiness, staff will add an objective in next year's plan once we have some baseline experience in SFY 03.

The Department of Education representative reminded staff to consider the work being done through the "Instructional Discipline" initiative and how mental health and others were serving on the steering committee.

Staff will revise text to make sure that this information is included.

The representatives from the Department for Juvenile Justice and the Department for Community Based Services asked to be included in the technical assistance meetings for the therapeutic foster care providers.

Staff will gladly send them the meeting notices and encourages their participation